



**TEXAS DEPARTMENT OF HEALTH**  
**PROMOTOR(A)/COMMUNITY HEALTH WORKER (CHW)**  
**APPLICATION FOR CERTIFICATION**

Items that are in **bold** must be completed. Items that are **not bold** and have an asterisk (\*) are optional.

**SECTION I. PERSONAL INFORMATION (Please Print or Type)**

Part A: Applicant Information

<b>Last Name</b>		<b>First Name</b>		<b>Middle Name/Initial*</b>
<b>Residence</b> (Physical Address)		(City)	(State)	[5 Digit Zip Code (9-digit if known)]
<b>Mailing</b> (If Different from Residence) (Street Address/P.O. Box)		(City)	(State)	[5 Digit Zip Code (9-digit if known)]
<b>Home Telephone</b> ( ) -	<b>FAX*</b> ( ) -	<b>Mobile/Cell*</b> ( ) -	<b>E-Mail Address*</b>	<b>Social Security Number*</b> - -

**SECTION II. BACKGROUND INFORMATION**

<b>Race/Ethnicity*</b> (check one) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other (specify) _____			
<b>Gender*</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Date of Birth</b> (MO/DY/YR) __ / __ / __	<b>Place of Birth*</b> (City/Town) (State) (Country)	
<b>Language(s) Usage*</b> English <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write Spanish <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write Other _____ <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write		<b>Prefer TDH Correspondence In*</b> (Choose one only) <input type="checkbox"/> English <input type="checkbox"/> Spanish	

**SECTION III. EDUCATION (United States or Other Country)**

<b>Highest Level of Education Completed</b> (check one) <input type="checkbox"/> Kindergarten–12th Grade (specify grade level) _____ <input type="checkbox"/> HS Graduate <input type="checkbox"/> General Educational Development (GED) <input type="checkbox"/> College/Community College (years completed) _____ <input type="checkbox"/> College Graduate <input type="checkbox"/> Advanced Degree(s)	
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**SECTION IV. CURRENT EMPLOYMENT OR VOLUNTEER WORK**

<b>Name of Employer/Supervisor</b>		<b>Name of Employment Organization/Agency</b>	
<b>Work Address</b> (Street Address) (City) (State) [Zip Code (9-digit)] (County)			
<b>Type of Business</b> (check one) <input type="checkbox"/> Community-Based Organization (CBO) <input type="checkbox"/> Clinic/Hospital <input type="checkbox"/> College/University/School <input type="checkbox"/> Faith-Based Organization <input type="checkbox"/> Local Health Department <input type="checkbox"/> Other (specify) _____			
<b>Work Duties</b> [Describe what you do/did as a community health worker or promotor(a)] (Check All That Apply) <input type="checkbox"/> Know and understand specific health issues <input type="checkbox"/> Communicate health information <input type="checkbox"/> Provide language services <input type="checkbox"/> Help complete applications for services <input type="checkbox"/> Make referrals to health and social service providers <input type="checkbox"/> Connect people to services <input type="checkbox"/> Assure people get health services they need <input type="checkbox"/> Work as a team member <input type="checkbox"/> Maintain positive relationships with others <input type="checkbox"/> Advocate on behalf of families and communities <input type="checkbox"/> Coach families on getting health services <input type="checkbox"/> Identify barriers to health care delivery <input type="checkbox"/> Provide health education <input type="checkbox"/> Plan and lead classes <input type="checkbox"/> Organize tasks and community groups <input type="checkbox"/> Manage priorities and time <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____			
<b>Number of Hours Worked Per Week</b>		<b>Work Status</b> <input type="checkbox"/> Paid <input type="checkbox"/> Unpaid	
<b>Work Telephone</b> ( ) -	<b>Work FAX*</b> ( ) -	<b>E-Mail Address*</b>	

**SECTION V. Experience** (Starting with the most recent experience, list all the Community Health Worker (CHW) or Promotor(a)-related experience you have) This section must be completed if you are applying under §146.7.b. regarding special provisions for persons who have performed at least 1,000 hours of services between July 1997–December 2002. If you need additional space to document your experience, please make copies of this form.

Part B: Experience

Last Name		First Name		Middle Name/Initial*
<b>A</b>	Date(s) of Experience	Name of Supervisor		Supervisor's Telephone
	Total Number of Hours of Service			( ) -
	Name of Organization/Agency	Agency Address (Street) (City) (State) (Zip Code)		
	<b>Work Duties</b> [Describe what you do/did as a community health worker or promotor(a)] (Check All That Apply) <input type="checkbox"/> Know and understand specific health issues <input type="checkbox"/> Communicate health information <input type="checkbox"/> Provide language services <input type="checkbox"/> Help complete applications for services <input type="checkbox"/> Make referrals to health and social service providers <input type="checkbox"/> Connect people to services <input type="checkbox"/> Assure people get health services they need <input type="checkbox"/> Work as a team member <input type="checkbox"/> Maintain positive relationships with others <input type="checkbox"/> Advocate on behalf of families and communities <input type="checkbox"/> Coach families on getting health services <input type="checkbox"/> Identify barriers to health care delivery <input type="checkbox"/> Provide health education <input type="checkbox"/> Plan and lead classes <input type="checkbox"/> Organize tasks and community groups <input type="checkbox"/> Manage priorities and time <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____			
<b>B</b>	Date(s) of Experience	Name of Supervisor		Supervisor's Telephone
	Total Number of Hours of Service			( ) -
	Name of Organization/Agency	Agency Address (Street) (City) (State) (Zip Code)		
	<b>Work Duties</b> [Describe what you do/did as a community health worker or promotor(a)] (Check All That Apply) <input type="checkbox"/> Know and understand specific health issues <input type="checkbox"/> Communicate health information <input type="checkbox"/> Provide language services <input type="checkbox"/> Help complete applications for services <input type="checkbox"/> Make referrals to health and social service providers <input type="checkbox"/> Connect people to services <input type="checkbox"/> Assure people get health services they need <input type="checkbox"/> Work as a team member <input type="checkbox"/> Maintain positive relationships with others <input type="checkbox"/> Advocate on behalf of families and communities <input type="checkbox"/> Coach families on getting health services <input type="checkbox"/> Identify barriers to health care delivery <input type="checkbox"/> Provide health education <input type="checkbox"/> Plan and lead classes <input type="checkbox"/> Organize tasks and community groups <input type="checkbox"/> Manage priorities and time <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____			
<b>C</b>	Date(s) of Experience	Name of Supervisor		Supervisor's Telephone
	Total Number of Hours of Service			( ) -
	Name of Organization/Agency	Agency Address (Street) (City) (State) (Zip Code)		
	<b>Work Duties</b> [Describe what you do/did as a community health worker or promotor(a)] (Check All That Apply) <input type="checkbox"/> Know and understand specific health issues <input type="checkbox"/> Communicate health information <input type="checkbox"/> Provide language services <input type="checkbox"/> Help complete applications for services <input type="checkbox"/> Make referrals to health and social service providers <input type="checkbox"/> Connect people to services <input type="checkbox"/> Assure people get health services they need <input type="checkbox"/> Work as a team member <input type="checkbox"/> Maintain positive relationships with others <input type="checkbox"/> Advocate on behalf of families and communities <input type="checkbox"/> Coach families on getting health services <input type="checkbox"/> Identify barriers to health care delivery <input type="checkbox"/> Provide health education <input type="checkbox"/> Plan and lead classes <input type="checkbox"/> Organize tasks and community groups <input type="checkbox"/> Manage priorities and time <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Other (specify) _____			
<b>FOR TDH USE ONLY</b>				
Total Number of Hours Within a 12-Month Period		Dates (MO/YR to MO/YR) / / to / /		

**SECTION VI. TRAINING** (Starting with the most recent training, list all the Community Health Worker-related training you have completed.) This section must be completed after you have received the training. If you have completed more than one training, make copies of this form for each instructor to sign. Part C: Training

Applicant's Last Name		Applicant's First Name		Applicant's Middle Name/Initial*	
<b>INSTRUCTOR/SPONSORING INSTITUTION INFORMATION</b>					
<b>A</b>	Date(s) of Training	Name of Course/Training		Name of Instructor/Sponsoring Institution	
	Work Telephone (   ) -   -   -	Work FAX* (   ) -   -   -	E-Mail Address*		
	Location of Training (Physical Address)		(City)	(State)	(Zip Code)
	Mailing Address (If Different From Physical Address)		(City)	(State)	(Zip Code)
	Instructor or Sponsoring Institution Signature			Date	
					<b>NUMBER OF HOURS COMPLETED</b>
<b>COMPETENCY</b>					
Communication Skills					
Interpersonal Skills					
Service Coordination Skills					
Capacity-Building Skills					
Advocacy Skills					
Teaching Skills					
Organizational Skills					
Knowledge Base					
<b>TOTAL CUMULATIVE TRAINING HOURS</b>					
Instructor or Sponsoring Institution Signature					Date

The eight core skill and knowledge competencies adopted by the certification program and identified in the National Community Health Advisor Study, June 1998, for promotores(as) or CHWs, are as follows:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Communication Skills             <ul style="list-style-type: none"> <li>- Listening</li> <li>- Use language confidently and appropriately</li> <li>- Ability to read and write well enough to document activities</li> </ul> </li> <li>• Interpersonal Skills             <ul style="list-style-type: none"> <li>- Counseling</li> <li>- Relationship-building</li> <li>- Ability to work as a team member</li> <li>- Ability to work appropriately with diverse groups of people</li> </ul> </li> <li>• Knowledge Base             <ul style="list-style-type: none"> <li>- Broad knowledge about the community</li> <li>- Knowledge about specific health issues</li> <li>- Knowledge of health and social service systems</li> <li>- Ability to find information</li> </ul> </li> <li>• Service Coordination Skills             <ul style="list-style-type: none"> <li>- Ability to identify and access resources</li> <li>- Ability to network and build coalitions</li> <li>- Ability to provide follow-up</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Capacity-Building Skills             <ul style="list-style-type: none"> <li>- "Empowerment"—Ability to identify problems and resources to help clients solve problems themselves</li> <li>- Leadership</li> <li>- Ability to strategize</li> <li>- Ability to motivate</li> </ul> </li> <li>• Advocacy Skills             <ul style="list-style-type: none"> <li>- Ability to speak up for individuals or communities and withstand intimidation</li> <li>- Ability to use language appropriately</li> <li>- Ability to overcome barriers</li> </ul> </li> <li>• Teaching Skills             <ul style="list-style-type: none"> <li>- Ability to share information one-on-one</li> <li>- Ability to master information, plan and lead classes, and collect and use information from community people</li> </ul> </li> <li>• Organizational Skills             <ul style="list-style-type: none"> <li>- Ability to set goals and plan</li> <li>- Ability to juggle priorities and manage time</li> </ul> </li> </ul> |
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## SECTION VII. APPLICATION SIGNATURE

Part D: Signature

Last Name	First Name	Middle Name/Initial*
<b>PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INDICATE YOUR UNDERSTANDING AND ACCEPTANCE BY SIGNING IN THE SPACE PROVIDED</b>		
<ul style="list-style-type: none"> <li>I certify that all the information provided by me in connection with this application, whether on this document or not, is true and complete. I understand that providing false or misleading information, which is material in determining my qualifications may result in the voiding of the application and failure to be granted any certificate or the revocation of any certificate issued.</li> <li>I understand the Health and Safety Code, Chapter 48 and The Rules Regarding the Training and Certification of Promotores(as) or Community Health Workers, 25 TAC §§146.1–146.10 and agree to abide by them.</li> <li>I give the Texas Department of Health (TDH) permission to verify any information or references, which are material to determining my qualifications.</li> <li>I will return the certificate and identification card(s) to TDH upon the expiration, revocation or suspension of the certificate.</li> <li>I understand that the application and supporting documentation submitted become the property of TDH and are nonreturnable.</li> <li>I shall advise the department of my current address within 30 days of any changes of address.</li> </ul>		
<b>THIS APPLICATION MUST BE SIGNED AND DATED</b>		
Signature		Date
<b>NOTARY</b>		
Full Name of Notary	County	State
		Commission Expires
Signature of Notary		Date of Signature

Send this completed application to: **Texas Department of Health, Promotor(a)/Community Health Worker Certification, 1100 West 49<sup>th</sup> Street, Suite T-608, Austin, Texas 78756-3199**

FOR TDH USE ONLY			
Total Number of Hours of Experience Within a 12-Month Period ____ / ____ / ____		Dates (MO/YR to MO/YR) ____ / ____ to ____ / ____	Application Form Completed <input type="checkbox"/> English <input type="checkbox"/> Spanish
Date Application Received (MO/DY/YR) ____ / ____ / ____		Application <input type="checkbox"/> Initial <input type="checkbox"/> Renewal	Entered By (Full Name)
Date Assigned to Committee (MO/DY/YR) ____ / ____ / ____		Committee Recommendation <input type="checkbox"/> Approve <input type="checkbox"/> Disapprove	Date Approved by TDH (MO/DY/YR) ____ / ____ / ____
Certificate Number	Audit Number	Date Certificate Mailed (MO/DY/YR) ____ / ____ / ____	Certificate Expiration Date (MO/DY/YR) ____ / ____ / ____

**PRIVACY NOTIFICATION**

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.tdh.state.tx/privacy.htm> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)



**TEXAS DEPARTMENT OF HEALTH  
PROMOTOR(A)/COMMUNITY HEALTH WORKER (CHW)  
TRAINING AND CERTIFICATION PROGRAM  
INSTRUCTIONS—APPLICATION FOR CERTIFICATION**

**HOW TO APPLY FOR CERTIFICATION AS A PROMOTOR(A)/COMMUNITY HEALTH WORKER**

1. All applicants must complete Part A (Personal Information). Items that are in bold must be completed. Items that are not bold and have an asterisk (\*) are optional.

**SECTION I. PERSONAL INFORMATION**

**SECTION II. BACKGROUND INFORMATION**

**SECTION III. EDUCATION**

**SECTION IV. CURRENT EMPLOYMENT OR VOLUNTEER WORK**

2. All applicants must complete either Part B (Experience) **or** Part C (Training)
  - a. **Part B—Section V. Experience**—Applicants who have not completed a certified training course, but have performed at least 1,000 hours of service within a 12-month period between July 1997–December 2002 as a promotor(a) or community health worker.
  - b. **Part C—Section VI. Training**—Applicants who have completed a certified training course.
3. **Section VII. Application Signature**—All applicants must sign and date Part D (Signature). Part D must be notarized.

**WHAT WE NEED FROM THE APPLICANT**

Submit a color photograph with your application (for example, 2"x2"). The face photo (frontal not profile) should be current (taken within the previous six months) and bears a good likeness of you. The photo should have a light background that clearly shows your facial features. The purpose of the photo is for use on the identification card. Photos will not be returned.

**RENEWAL OF CERTIFICATION**

If your application is approved, you will be sent a Certificate of Competence, which is valid for two (2) years. You must apply to renew your certificate before it expires or it will no longer be valid. Please send any changes in your address to the Office of Public Health Practice or you will not receive a renewal notice.

**DENIAL OF CERTIFICATION**

Your application for certification may be denied for any of these reasons:

- It is incomplete.
- You do not meet the requirements for certification listed in the rules.
- You have provided false information on the application.
- The Texas Department of Health has reason to believe that you should not be issued a Certificate of Competence due to unethical conduct, illness, your physical or mental condition, or drug or alcohol dependency.

**TIMELINES**

Within 30 days of receiving your application, the Texas Department of Health will inform you if your application is approved, denied and why, or incomplete. Mail your original, completed application and photograph with copies of supporting documentation to (keep a copy of all materials submitted for your records):

**Texas Department of Health  
Promotor(a)/Community Health Worker Certification  
1100 West 49<sup>th</sup>, Suite T-608  
Austin TX 78756-3199**

For a copy of the rules and other information about certification, please see TDH website at: [www.tdh.state.tx.us/php/chw/chw.htm](http://www.tdh.state.tx.us/php/chw/chw.htm)  
For questions or more information, please contact the Office of Public Health Practice at [CHW@tdh.state.tx.us](mailto:CHW@tdh.state.tx.us) or (512) 458-7770.